907 KAR 5:005. Health Insurance Premium Payment (HIPP) Program.

RELATES TO: 42 U.S.C. 1396e(a)-(e)

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3), 205.560(2), 42 U.S.C. 1396e(a)-(e).

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed, or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. 42 U.S.C. 1396e(a) through (e) authorizes states to establish a health insurance premium payment, or HIPP, program to provide health insurance coverage outside of Medicaid to Medicaid enrollees, and any family member of Medicaid enrollees if the department determines that HIPP program participation would be cost effective for the department. This administrative regulation establishes Kentucky's health insurance premium payment program requirements as authorized by 42 U.S.C. 1396e(a) through (e).

Section 1. Definitions. (1) "Buying in" means purchasing benefits from Medicare on behalf of an individual.

(2) "Department" means the Department for Medicaid Services or its designee.

(3) "Federal financial participation" is defined in 42 C.F.R. 400.203.

(4) "Group health insurance plan" means any plan, including a self-insured plan, of, or contributed to by, an employer to provide health care directly or otherwise to the employer's employees, former employees, or the families of the employees or former employees, if the plan:

(a) Meets the criteria established in 26 U.S.C. 5000(b)(1); and

(b) Includes continuation coverage pursuant to 26 U.S.C. 4980B or 29 U.S.C. 1161 to 1169.

(5)"'Health insurance premium payment program participant" or "HIPP program participant" means an individual receiving health insurance benefits in accordance with this administrative regulation.

(6) "Income" means:

(a) Wages, salary, or compensation for labor or services;

(b) Money received from a statutory benefit including Social Security, Veteran's Administration pension, black lung benefit, or railroad retirement benefit; or

(c) Money received from any pension plan, rental property, or an investment including interest or dividends.

(7) "Income deduction" means a deduction from an individual's income for the purpose of obtaining or trying to obtain Medicaid eligibility.

(8) "Medicaid" means the Kentucky Medicaid program.

(9) "Medicaid enrollee" means an individual eligible for and participating in Medicaid pursuant to 907 KAR 1:011, 907 KAR 1:605, 907 KAR 1:640, and 907 KAR 1:645.

(10) "Spend-down program" means a program by which an individual becomes eligible for Medicaid benefits:

(a) By spending down income in excess of the Medicaid income threshold; and

(b) In accordance with 907 KAR 1:640.

(11) "State plan" is defined in 42 C.F.R. 430.10.

(12) "Wrap-around coverage" means coverage of a benefit not covered by an individual's group health insurance plan.

Section 2. HIPP Program Eligibility and Enrollment. (1) A Medicaid enrollee, or a person act-

ing on the Medicaid enrollee's behalf, shall cooperate in providing information to the department necessary for the department to establish availability and cost effectiveness of a group health insurance plan by:

(a) Completing the Kentucky Health Insurance Premium Payment Program Application; and

(b) Submitting the Kentucky Health Insurance Premium Payment Program Application to the individual's local Department for Community Based Services office.

(2) If a Medicaid enrollee HIPP program applicant, participant, parent, guardian, or caretaker fails to provide information to the department, within ten (10) days of the department's request, necessary to determine availability and cost effectiveness of a group health insurance plan, the department shall not enroll the applicant in the HIPP program unless good cause for failure to cooperate is demonstrated to the department within thirty (30) days of the department's denial.

(3) Good cause for failure to cooperate shall exist if:

(a) There was a serious illness or death of the applicant, participant, parent, guardian, or caretaker or of a member of the applicant's, participant's, parent's, guardian's, or caretaker's immediate family;

(b) There was a fire, tornado, flood, or similar family emergency or household disaster;

(c) The applicant, participant, parent, guardian, or caretaker demonstrates that a good cause beyond that individual's control occurred; or

(d) There was a failure to receive the department's request for information or notification for a reason not attributable to the applicant, participant, parent, guardian, or caretaker occurred. The lack of a forwarding address shall be attributable to the applicant, participant, parent, guardian, or caretaker.

(4) For a Medicaid enrollee who is a HIPP program participant:

(a) The department shall pay all group health insurance plan premiums and deductibles, coinsurance and other cost-sharing obligations for items and services otherwise covered under Medicaid; and

(b)1. The individual's group health insurance plan shall be the primary payer; and

2. The department shall be the payer of last resort.

(5) For a HIPP program participating family member who is not a Medicaid enrollee:

(a) The department shall pay a HIPP program premium; and

(b) Not pay a deductible, coinsurance or other cost-sharing obligation.

(6) If an individual who was a Medicaid enrollee at the time the department initiated a HIPP program cost effectiveness review for the individual loses Medicaid eligibility by the time the cost effectiveness review has been conducted, the department shall not enroll the individual or any family member into the HIPP program.

Section 3. Wrap-around Coverage. (1) If a service to which a health insurance premium payment program participant would be entitled via Medicaid is not provided by the individual's group health insurance plan, the department shall reimburse for the service.

(2) For a service referenced in subsection (1) of this section, the department shall reimburse:

(a) The provider of the service; and

(b) In accordance with the department's administrative regulation governing reimbursement for the given service. For example, a wrap-around dental service shall be reimbursed in accordance with 907 KAR 1:626.

Section 4. Cost Effectiveness. (1) Enrollment in a group health insurance plan shall be considered cost effective if the cost of paying the premiums, coinsurance, deductibles and other cost-sharing obligations, and additional administrative costs is estimated to be less than the

amount paid for an equivalent set of Medicaid services.

(2) When determining cost effectiveness of a group health insurance plan, the department shall consider the following information:

(a) The cost of the insurance premium, coinsurance, and deductible;

(b) The scope of services covered under the insurance plan, including exclusions for pre-existing conditions, exclusions to enrollment, and lifetime maximum benefits imposed;

(c) The average anticipated Medicaid utilization:

1. By age, sex, and coverage group for persons covered under the insurance plan; and

2. Using a statewide average for the geographic component;

(d) The specific health-related circumstances of the persons covered under the insurance plan; and

(e) Annual administrative expenditures of an amount determined by the department per Medicaid participant covered under the group health insurance plan.

Section 5. Cost Effectiveness Review. (1) The department shall complete a cost effectiveness review:

(a) At least once every six (6) months for an employer-related group health insurance plan; or

(b) Annually for a non-employer-related group health insurance plan.

(2) The department shall perform a cost effectiveness re-determination if:

(a) A predetermined premium rate, deductible, or coinsurance increases;

(b) Any of the individuals covered under the group health insurance plan lose full Medicaid eligibility; or

(c) There is a:

1. Change in Medicaid eligibility;

2. Loss of employment if the insurance is through an employer; or

3. Decrease in the services covered under the policy.

(3)(a) A health insurance premium payment program participant who is a Medicaid enrollee, or a person on that individual's behalf, shall report all changes concerning health insurance coverage to the participant's local Department for Community Based Services (DCBS), Division of Family Support within ten (10) days of the change.

(b) Except as allowed in subsection (4) of this section, if a Medicaid enrollee who is a health insurance premium payment program participant fails to comply with paragraph (a) of this subsection, the department shall disenroll from the HIPP program the HIPP program participating Medicaid enrollee, and any family member enrolled in the HIPP program directly through the individual if applicable.

(4) The department shall not disenroll an individual from HIPP program participation if the individual demonstrates to the department, within thirty (30) days of notice of HIPP program disenrollment, good cause for failing to comply with subsection (3) of this section.

(5) Good cause for failing to comply with subsection (3) of this section shall exist if:

(a) There was a serious illness or death of the individual, parent, guardian, or caretaker or a member of the individual's, parent's guardian's, or caretaker's immediate family;

(b) There was a fire, tornado, flood, or similar family emergency or household disaster;

(c) The individual, parent, guardian, or caretaker demonstrates that a good cause beyond that individual's control occurred; or

(d) There was a failure to receive the department's request for information or notification for a reason not attributable to the individual, parent, guardian, or caretaker. The lack of a forwarding address shall be attributable to the individual, parent, guardian, or caretaker.

Section 6. Coverage of Non-Medicaid Family Members. (1) If determined to be cost effective, the department shall enroll a family member who is not a Medicaid enrollee into the HIPP program if the family member has group health insurance plan coverage through which the department can obtain health insurance coverage for a Medicaid-enrollee in the family.

(2) The needs of a family member who is not a Medicaid enrollee shall not be taken into consideration when determining cost effectiveness of a group health insurance plan.

(3) The department shall:

(a) Pay a HIPP program premium on behalf of a HIPP program participating family member who is not a Medicaid enrollee; and

(b) Not pay a deductible, coinsurance, or other cost-sharing obligation on behalf of a HIPP program participating family member who is not a Medicaid enrollee.

Section 7. Exceptions. The department shall not pay a premium:

(1) For a group health insurance plan if the plan is designed to provide coverage for a period of time less than the standard one-year coverage period;

(2) For a group health insurance plan if the plan is a school plan offered on the basis of attendance or enrollment at the school;

(3) If the premium is used to meet a spend-down obligation and all persons in the household are eligible or potentially eligible only under the spend-down program pursuant to 907 KAR 1:640. If any household member is eligible for full Medicaid benefits, the premium shall:

(a) Be paid if it is determined to be cost effective when considering only the household members receiving full Medicaid coverage; and

(b) Not be allowed as a deduction to meet the spend-down obligation for those household members participating in the spend-down program.

(4) For a group health insurance plan if the plan is an indemnity policy which supplements the policy holder's income or pays only a predetermined amount for services covered under the policy.

Section 8. Duplicate Policies. (1) If more than one (1) group health insurance plan or policy is available, the department shall pay only for the most cost-effective plan except as allowed in subsection (2) of this section.

(2) If the department is buying in to the cost of Medicare Part A or Part B for an eligible Medicare beneficiary, the cost of premiums for a Medicare supplemental insurance policy shall also be paid if the department determines that it is likely to be cost effective to do so.

Section 9. Discontinuance of Premium Payments. (1) If all Medicaid-enrollee household members covered under a group health insurance plan lose Medicaid eligibility, the department shall discontinue HIPP program payments as of the month of Medicaid ineligibility.

(2) If one (1) or more, but not all, of a household's Medicaid-enrollee members covered under a group health insurance plan lose Medicaid eligibility, the department shall re-determine cost effectiveness of the group health insurance plan in accordance with Section 5(2) of this administrative regulation.

Section 10. Health Insurance Premium Payment Program Payment Effective Date. (1)(a) HIPP program payments for cost-effective group health insurance plans shall begin with the month the health insurance premium payment program application is received by the department, or the effective date of Medicaid eligibility, whichever is later.

(b) If an individual is not currently enrolled in a cost effective group health insurance plan, premium payments shall begin in the month in which the first premium payment is due after en-

rollment occurs.

(2) The department shall not make a payment for a premium which is used as an income deduction when determining individual eligibility for Medicaid.

Section 11. Premium Refunds. The department shall be entitled to any premium refund due to:

(1) Overpayment of a premium; or

(2) Payment for an inactive policy for any time period for which the department paid the premium.

Section 12. Notice. The department shall inform a health insurance premium payment program:

(1) Applicant, in writing, of the department's initial decision regarding cost effectiveness of a group health insurance plan and HIPP program payment; or

(2) Participating household, in writing:

(a) If HIPP program payments are being discontinued due to Medicaid eligibility being lost by all individuals covered under the group health insurance plan;

(b) If the group health insurance plan is no longer available to the family; or

(c) Of a decision to discontinue HIPP program payment due to the department's determination that the policy is no longer cost effective.

Section 13. Federal Financial Participation. (1) The department's health insurance premium program shall be contingent upon the receipt of federal financial participation for the program.

(2) If federal financial participation is not provided to the department for the department's health insurance premium program, the program shall cease to exist.

(3) If the Centers for Medicare and Medicaid Services (CMS) disapproves a provision stated in an amendment to the state plan, which is also stated in this administrative regulation, the provision shall be null and void.

Section 14. Incorporation by Reference. (1) The "Kentucky Health Insurance Premium Payment Program Application", September 2010 edition, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m., or from the department's Web site at http://www.chfs.ky.gov/dms/incorporated.htm. (37 Ky.R. 986; eff. 11-05-2010.)